

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



HOSPICE SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

A hospice is a public agency or private organization or a subdivision of either of these that is primarily engaged in providing care and services to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has a valid provider contract. Hospice coverage for South Carolina Medicaid beneficiaries is available for an unspecified number of days, subdivided into election periods as follows: two periods of 90 days each, and an unlimited number of subsequent periods of 60 days each. Benefit periods can be used consecutively or at different times during the beneficiary's life span. At the beginning of each period, the beneficiary must be certified by a physician as terminally ill with a life expectancy of six months or less.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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COVERED POPULATIONS

ELIGIBILITY

In order for a Medicaid beneficiary to be eligible to elect hospice care under Medicaid, the beneficiary must be certified as being terminally ill. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the disease runs its normal course

ELECTION PROCEDURES

Individuals who elect to receive hospice care must file a Medicaid Hospice Election Form (Department of Health and Human Services [DHHS] Form 149) (see Forms section) with a particular hospice. This required form includes the hospice provider identifying information. An election may also be filed by a family member or a patient representative. With respect to an individual granted the power of attorney for the patient, or acting as an agent of the patient under a Durable Power of Attorney for Health Care, state law determines the extent to which the individual may act on the patient's behalf. All forms must be filled out completely to be accepted by South Carolina Department of Health and Human Services (SCDHHS).

An election to receive hospice care will be considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date the election is made.

For purposes of the Medicaid hospice benefit, a nursing facility (NF) can be considered the residence of a beneficiary. A beneficiary residing in such a setting may elect the hospice benefit.

If the hospice is placing a patient in a NF utilizing a Medicaid-certified bed, the procedures for pre-admission screening by Community Long Term Care must be followed.

Revoking Hospice Election

An individual or legal representative may revoke the election of hospice care at any time. To do so, the individual must file a Medicaid Hospice Revocation Form (DHHS Form 153) with the hospice, along with a signed statement indicating all of the following:

- That the beneficiary revokes the election for Medicaid coverage for any remaining days in the election period.
- That the beneficiary is aware of the revocation.

- Why the beneficiary has chosen to revoke hospice services.

An individual may not designate an effective date earlier than the date the revocation is made.

Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected, effective on the date of revocation. The hospice must submit the Medicaid Hospice Revocation Form (DHHS Form 153) to SCDHHS within five working days of the revocation. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

When a beneficiary is noncompliant, the hospice may advise the beneficiary of the option to revoke the benefit and any advantages and disadvantages related to the decision. A beneficiary is considered to be noncompliant if any of the following occur:

- The beneficiary seeks aggressive treatment for the terminal illness.
- The beneficiary receives treatment in a facility that does not have a contract with the hospice.
- The beneficiary receives treatments that are not in the hospice plan of care (POC) or are not pre-authorized by the hospice.

Discharge

A hospice can discharge (not revoke) a beneficiary for the following reasons:

- The beneficiary dies.
- The beneficiary is noncompliant.
- The beneficiary is determined to have a prognosis greater than six months.
- The beneficiary moves out of the hospice's geographically defined service area.
- The safety of the patient or of the hospice staff is compromised.

The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem must be documented in detail in the beneficiary's clinical record. The hospice must notify the SCDHHS hospice program manager and the state survey agency of the circumstances surrounding controversial impending discharges where noncompliance or safety issues are the cause or the causes for discharge. Whatever the reason for discharge, the hospice must clearly document why the patient was discharged from the hospice benefit.

When discharging a beneficiary, the Medicaid provider must submit a Medicaid Hospice Discharge Form (DHHS Form 154) to SCDHHS within five working days of the discharge. When discharging

for reasons other than death, the hospice must send a copy of the Medicaid Hospice Discharge Form to the beneficiary or responsible party upon discharge. The reverse side of the Medicaid Hospice Discharge Form contains the appeals procedures provided for each Medicaid beneficiary when adverse action is taken against that beneficiary. When forwarding a copy of this completed form, the provider must ensure that the reverse side of the form is included.

A hospice provider may not discharge a beneficiary who has revoked the Medicaid hospice benefit. Therefore, a Medicaid Hospice Discharge Form should not be completed when a revocation is made.

Appeals

When a Medicaid beneficiary is discharged from a hospice program for one of the reasons listed under “Discharge,” the beneficiary has the right to a fair hearing regarding the decision. Beneficiaries and their legal representatives have the right to appeal the hospice discharge within 30 days of the receipt of the Medicaid Hospice Discharge Form by submitting a written request to the following address:

Department of Health and Human Services
Director, Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

The request must state specifically, which issues are being appealed and must be accompanied by a copy of the Medicaid Hospice Discharge Form.

A request for a fair hearing is considered filed if postmarked by the thirtieth calendar day following receipt of the Medicaid Hospice Discharge Form. Both the Medicaid beneficiary and the provider will be notified of the date, time, and place the fair hearing will take place.

Dually Eligible Beneficiaries

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. In other words, if a Medicaid beneficiary elects the hospice Medicaid benefit and is also eligible for Medicare, then the beneficiary must also elect the Medicare hospice benefit. If a Medicare beneficiary elects the hospice Medicare benefit and is also eligible for Medicaid, then the beneficiary must also elect the Medicaid hospice benefit.

For dually eligible beneficiaries, Medicare is the primary payer for the hospice benefit, though the Medicaid hospice election process must also be completed. Revocation, discharge and change of provider procedures must be followed and designated forms completed as specified in this section. A flowchart of the documentation submission process can be found at the end of this section.

Retroactive Eligibility

Individuals who have applied for Medicaid eligibility can elect the hospice benefit while their applications are pending approval. If an individual is determined eligible, SCDHHS may pay the hospice for services delivered while the eligibility determination was pending. Eligibility can be retroactive for a maximum of three months.

If an individual has not been determined Medicaid eligible, but meets all other criteria to elect the Medicaid hospice benefit, he or she may elect the hospice benefit by completing the documentation required for prior authorization of hospice services. (i.e., DHHS Form 149, Medicaid Hospice Election Form [include the effective date in the Elective Date block], Physician Certification/Recertification, SCDHHS Form 151, Hospice POC and supporting documentation).

Once the individual is notified of his or her Medicaid eligibility, the beneficiary identification number must be entered on the signed and dated election form and physician certification form (DHHS 149 and 151). At this time, all documentation must be submitted to KEPRO to request prior authorization of hospice services. The hospice agency may continue to verify the beneficiary's eligibility status by using the Web Tool. See the Provider Administrative and Billing Manual for more information.

A hospice agency cannot submit a claim form for payment until after the beneficiary has been determined Medicaid eligible, and at no time can reimbursement be requested for dates of service prior to the actual date of election.

A hospice agency that elects an individual whose Medicaid eligibility has not been determined assumes all liability for services the individual may receive, whether or not that individual is determined to be eligible. All liability rules are effective as though the individual has already been determined to be eligible (e.g., hospitalizations related to the terminal illness). A hospice agency cannot solicit payment from the individual for services that may be provided after the Medicaid hospice benefit has been elected.

General information regarding retroactive eligibility claim submission can be found in the Provider Administrative and Billing Manual.

Waiver of Medicaid Services

An individual must waive all rights to other Medicaid benefits for the duration of the election of hospice care for the services below:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).
- Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for the following types of services:
 - Services provided (either directly or under arrangement) by the designated hospice.

- Services provided by another hospice under arrangements made by the designated hospice.
- Services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for the services.

After the hospice benefit expires, the patient's waiver of these other Medicaid benefits expires and coverage of certain services provided through the hospice may be possible. For example, if the patient requires a covered Medicaid service such as acute inpatient care, home health, durable medical equipment (DME), or pharmaceutical services, and the hospice benefit expires and has not been renewed, the providers of those services may bill South Carolina Medicaid directly if they are authorized Medicaid providers.

The hospice must determine whether the beneficiary is receiving other Medicaid waiver services, such as Community Long Term Care (CLTC). If other services are being provided, the hospice and CLTC need to work together to ensure that the beneficiary is getting the best care possible.

For eligible individuals who are enrolled in both CLTC and Medicaid hospice, the CLTC provider may only be reimbursed for Case Management, Home Delivered Meals and Personal Emergency Response Systems. It is important for the hospice provider and the CLTC provider to communicate these changes in services to all potential hospice enrollees prior to the start of hospice care.

If the eligible beneficiary is enrolled in the human immunodeficiency virus or Vent waivers, he or she may be authorized to have up to two additional prescriptions, but not authorized to have Companion services.

Hospice Care for Minors (Persons Under the Age of 21) Enrolled in Medicaid

SCDHHS will provide reimbursement for hospice services for minors under 21 years of age in conjunction with curative treatment of the child's terminal illness.

Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children" removes the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of minors enrolled in Medicaid or Children's Health Insurance Program.

This provision does not change the criteria for hospice.

A physician must certify that the minor is terminally ill, with a life expectancy of six months or less. This provision allows parents with minors under the age of 21, receiving hospice services to no longer forgo any other services to which the minor is entitled to under Medicaid treatment of the terminal condition. Services rendered by a provider other than the hospice must be discussed and coordinated with the hospice provider.

Hospice Services for Residents of NFs or Intermediate Care for Individuals with Intellectual Disabilities (ICF/IDD)

Participation with Skilled Nursing Facility (SNF), NF, ICF/IDD or Non-Certified Facility

The term “home” is not to be limited for hospice beneficiaries. A beneficiary’s home is where he or she resides. A hospice may furnish routine or continuous home care to a beneficiary who resides in a SNF, NF or ICF/IDD or a facility not eligible for Medicare or Medicaid such as a Community Residential Care Facility. The facility is considered to be the beneficiary’s place of residence (the same as a house or apartment), and the Medicaid facility resident may elect the hospice benefit if he or she also meets the hospice eligibility criteria.

The hospice then assumes full responsibility for professional management of the individual’s hospice care in accordance with the Hospice Conditions of Participation (42 CFR 418) and makes any arrangements necessary for inpatient care in a participating Medicare or Medicaid facility.

Notification of NF Utilization

The Medicaid hospice program manager must be notified in writing by the hospice when either of the following occurs:

- A Medicaid beneficiary who is a NF resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit.
- A Medicaid-sponsored NF resident elects the hospice benefit under the Medicaid hospice program.

A Medicaid Hospice Election Form must be completed and forwarded to the hospice program manager as described under “Election Procedures” with the facility address in the appropriate section for the beneficiary’s address.

Compliance with SNF/NF and ICF/IDD: Conditions of Participation

A Medicaid hospice provider must have a written agreement with a facility specifying that the SNF/NF Conditions of Participation (42 CFR 483) or the Conditions of Participation for an ICF/IDD (42 CFR 483.400 Subpart I) are applicable to all residents in the facility. Hospice beneficiaries are no exception. This means that the resident must be assessed using the information contained in the appropriate assessment instrument; have a POC, which, in this case, will be jointly developed and agreed upon by the hospice and facility and be provided with all services contained in the POC.

When a resident of a facility elects the Medicaid hospice benefit, the hospice and the facility must communicate, establish and agree upon one coordinated POC for both providers. The POC must also reflect the hospice philosophy and be based on an assessment of the individual’s needs and unique living situation in the NF. The POC must include the individual’s current medical, physical, psychosocial and spiritual needs. The hospice must designate a registered nurse from the hospice to coordinate the implementation of the POC.

An emergency plan, including telephone numbers that may be used in cases of beneficiary emergency, must also be left with the facility.

Professional Responsibility Coordination

The facility and the hospice are responsible for performing their respective functions agreed upon and included in the POC. The POC should reflect the participation of the hospice, facility and the resident to the greatest extent possible. The hospice and facility must communicate with each other when any changes are indicated to the POC.

The hospice retains overall professional management responsibility for directing the implementation of the POC.

All covered hospice services must be available as necessary to meet the needs of the patient. All core services must be routinely provided directly by hospice employees and cannot be delegated to the facility. Nursing care, physicians' services, medical social services and counseling are considered to be core hospice services.

The facility nursing personnel may assist with the administration of prescribed therapies included in the POC only to the extent that the hospice would routinely rely on the services of a hospice patient's family or caregiver in implementing the POC.

Drugs and medical supplies must be routinely provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice.

Evidence of this coordinated POC must be present in the clinical records of both providers. All aspects of the POC should reflect the hospice philosophy.

The hospice beneficiary residing in a facility should not experience any lack of facility services or personal care because of his or her status as a hospice beneficiary. The facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The hospice beneficiary has the right to refuse any services.

Non-Core Services

The hospice may arrange to have non-core hospice services provided by the facility if the hospice assumes professional management responsibility for these services and ensures that these services are performed in accordance with the policies of the hospice and the patient's POC. Non-core services are considered to be the provision of medical appliances and supplies, including drugs and biologicals, home health aide services, physical therapy, occupational therapy and speech language pathology services.

Hospice Beneficiaries Entering a NF from the Community or a Hospital

When a Medicaid beneficiary who has elected the hospice benefit in the community subsequently requires placement in a NF for long-term care, additional eligibility determinations must be completed before the beneficiary can receive Medicaid CLTC sponsorship. The authorization of medical necessity, or pre-admission review, is a function of LTC). A Pre-Admission Screening and Annual Resident Review (PASARR) determination is also completed by CLTC, NF or a hospital by a signed memorandum of agreement (MOA). The financial eligibility portion is determined by Medicaid eligibility staff.

Level of Care (LOC) Certification

The CLTC nurse consultant must be contacted and a pre-admission review completed in order for a beneficiary to be determined medically eligible. Medicaid vendor payment is authorized by the issuance of the LOC Certification letter, DHHS Form 185, which certifies medical necessity.

If a beneficiary receives a Medicare-qualifying skilled service for a condition unrelated to the terminal diagnosis, Medicare will pay the NF and hospice benefit.

If a beneficiary receives a Medicare-qualifying skilled service for a condition related to the terminal diagnosis, Medicare will only pay for the hospice benefit. In this situation, CLTC will certify for Medicaid sponsorship if all criteria are met.

If the beneficiary is not Medicare eligible, CLTC will certify the beneficiary following its usual procedures.

PASARR

The PASRR screening is a federally mandated program that requires each state to screen individuals for any indication of mental illness or intellectual disabilities. CLTC will refer to the appropriate agency if the screenings reveal indicators of mental illness or intellectual disabilities. A referral must be made to the appropriate CLTC office for this screening. Most nursing facilities and hospitals have a Memorandum of Agreement with CLTC to perform this screening.

Financial Eligibility

The beneficiary must meet additional financial eligibility requirements before Medicaid will sponsor a stay in a long-term care facility. Once the SCDHHS eligibility worker determines financial eligibility, a signed DHHS Form 181 is sent to the NF.

The NF attaches a copy of the DHHS Form 181 to the billing invoice for the resident at the end of the billing period and forwards that invoice to the hospice agency for reimbursement. The DHHS Form 181 verifies the resident's applicable recurring income.

If the hospice beneficiary decides to revoke his or her hospice election, the hospice provider must notify the NF of the revocation in writing, indicating the effective date. The NF would then initiate billing procedures as usual

Medicaid Bed Hold Days

If a Medicaid NF resident should require a short-term hospitalization with the expectation of returning to the NF, the NF will reserve the bed for up to 10 days. Reimbursement for the bed hold will be the responsibility of the hospice agency. Medicaid will reimburse the hospice agency for up to 10 consecutive bed hold days if both criteria, short-term stay and expectation of returning to the facility, are met. However, Medicaid reimbursement will not be provided for NF bed-hold days for dually eligible and Medicaid only hospice beneficiaries receiving general inpatient (GIP) care. If the beneficiary intends to return to the NF, it is the hospice responsibility to negotiate room and board rate with the NF to hold the patient's bed.

SCDHHS will continue to reimburse hospice providers limited to 10 NF bed-hold days in combination with payment for routine care services provided to the beneficiary

Therapeutic Care Deinstitutionalization Program

A Medicaid NF resident may leave the facility for up to eighteen days each fiscal year with expectation of Medicaid sponsorship for the absence. Each period of leave may be for a maximum of 9 days, and periods may not be consecutive. The POC must include the attending physician's authorization for home leave.

Chart entries should include:

- The length of time for which the leave was approved.
- The goal of the leave.
- On the resident's return, the results of the leave in relation to the goal.

The hospice agency then submits a claim to the Medicaid agency for reimbursement for these days and subsequently reimburses the NF. The hospice agency is expected to continue with routine home care should the resident leave the facility.

Notification of Death

The hospice agency is required to notify the NF and the SCDHHS eligibility worker of the date of death, using the SCDHHS Form 154, Medicaid Hospice Discharge Form. Due to the potential difficulty of obtaining a signature on the Form 154 following the death of a beneficiary, the signature is not required on the form in the circumstance of discharge by death. After notification, the NF will submit a final invoice to the hospice agency. This invoice will not include the date of death for reimbursement.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

In addition to conditions of participation in the Medicaid program outlined in the Provider Administrative and Billing Manual, the following also apply to hospices in order to participate in the Medicaid program:

- The hospice must be currently licensed under the provisions of South Carolina state law.
- The hospice must meet Title XVIII standards for Medicare participation and be certified as eligible for participation in the Medicare program.
- The hospice must develop written policies and procedures on advance directives in compliance with Section 1902(a) (57) of the Social Security Act.
- The hospice must attend provider orientation conducted by the SCDHHS. Provider orientation will be held at a minimum one time a year. To attend a session, a written request to become a Medicaid hospice provider must be mailed to:

Department of Health and Human Services
Division of Community and Facility Services
Post Office Box 8206
Columbia South Carolina 29202-8206.

The Provider Enrollment Form and SCDHHS Provider Contract will be supplied upon completion of the session.

In addition to completing a Provider Enrollment Form and a SCDHHS Provider Contract, a hospice must also submit all of the following information to the hospice program manager:

- A copy of the letter from the South Carolina Department of Health and Environmental Control (SCDHEC), Division of Health Licensing, showing the license number and the effective date of the license or a copy of the current license.
- A copy of the letter from the SCDHEC, Division of Survey and Certification, showing that the hospice has been recommended for certification or meets the requirements for the Medicare program.
- A copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved reimbursement rate, the fiscal year end and Medicare Provider ID number.

In compliance with Section 1902(a)(57) of the Social Security Act, a hospice must do all of the following:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives.
- Document in the patient's medical record whether or not an advance directive has been executed.
- Comply with all requirements of state law respecting advance directives.
- Provide (individually or with others) education for staff and the community on issues concerning advance directives.
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

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COVERED SERVICES AND DEFINITIONS

In order for hospice services to be covered, they must be deemed reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with the provisions described under “Election Procedures.” A certification that the individual is terminally ill must be completed as set forth under “Physician Certification.” A POC must be established before services are provided; services rendered must be consistent with the POC.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The services below are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker who has at least a bachelor’s degree and is working under the direction of a physician.
- Physicians’ services provided by the hospice medical director or physician member of the interdisciplinary group. Such services must be performed by a doctor of medicine or osteopathy. The following services performed by hospice physicians are included in the hospice rates and may not be billed as a physician’s service:
 - General supervisory services performed by the medical director.
 - Participation in the establishment of POC, supervision of care and services, periodic review and updating of care plans and establishment of governing policies by the physician member of the interdisciplinary group.

See “Payment for Physician Services” for additional information regarding the payment of physician services not related to the above.

- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual’s family or other caregiver to provide care and for the purpose of helping the individual and those caring for him or her to adjust to the individual’s approaching death.
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient areas. GIP care may be required for procedures necessary for

pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a nursing home.

- Medical appliances and supplies, including drugs and biologicals. Only drugs used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered DME as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written POC.
- Home health aide services furnished by qualified aides. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse.
- Homemaker services, including assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the POC.
- Physical therapy, occupational therapy and speech language pathology services provided for purpose of symptom control or to enable the individual to maintain activities of daily living and basic functional skills

NON-COVERED SERVICES

Respite care and continuous care are only reimbursed within certain limits. These are discussed in detail under LOC.

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service, but is not reimbursable.

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UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

SCDHHS requires prior authorization for Medicaid hospice services and medical record review prepayment from our Quality Improvement Organization, KEPRO.

For Medicaid-only or Medicare Part B-only beneficiaries, in which Medicaid is the primary payer of services or Medicaid payment will be requested as a secondary payer, hospice services must be approved by KEPRO within the 15 days of the first day of service.

For dually eligible beneficiaries for Medicare is the primary payer of hospice services, prior authorization is not required upon the election of the Medicaid hospice benefit. However, the forms for election, revocation and/or discharge of the hospice benefit must be submitted to SCDHHS.

To complete the prior authorization process, the following documentation must be submitted for review:

- KEPRO Prior Authorization Hospice Request Form.
- Medicaid Hospice Election Form (DHHS Form 149).
- Medicaid Hospice Physician Certification/Recertification Form (SCDHHS Form 151).
- Hospice POC.
- Clinical information and other documentation that supports the medical prognosis and shows the degree of impairment.

Clinical documentation may include, but not be limited to, current subjective and objective medical findings, related diagnosis(es), current medications and treatment orders and a summary of current medical treatment.

POC

Providers must design a POC for each beneficiary before rendering hospice services. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet with or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial POC. At least one of the persons involved in developing the initial plan must be a nurse or physician. The other two members of the basic

inter-disciplinary group must review the initial POC and provide their input to the process of establishing the POC within two calendar days following the day of assessment. A physician must sign the established POC.

Physician Certification

The hospice must obtain certification that an individual is terminally ill in accordance with the procedures below, using the Medicaid Hospice Physician Certification/Recertification Form (SCDHHS Form 151).

No certification or recertification forms are required if the beneficiary has also elected the Medicare hospice benefit. In other words, the certification or recertification notification for dual eligibility, when Medicare is primary, is not required.

The hospice must ensure that all of the following conditions are met:

- The attending physician must be a doctor of medicine or osteopathy and be identified by the individual at the time of hospice election as having the most significant role in the determination and delivery of the individual's medical care.
- For the first election of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, (that is by the end of the third day), written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).
- If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these two days, and a written certification must be obtained before a request for prior authorization of payment for hospice services. If these requirements are not met, no payment can be made for days prior to the certification. Certifications may be completed no more than fifteen days prior to the effective date of the election.
- For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement using SCDHHS Form 151, prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the physician's signature and a statement that the individual's medical prognosis is of a life expectancy of six months or less if the terminal illness runs its normal course.

The hospice must retain the certification statements in accordance with South Carolina statute of limitations requirements. For beneficiaries that are eligible for Medicaid only, a copy of the initial physician certification statement and when applicable, recertification statements must be submitted with the prior authorization request.

Submission Requirements

All requests for Prior Authorization must be received by KEPRO before the service is performed. In an emergency or any unplanned situation, the request must be received by KEPRO within five business days of the date of service.

The response time for a decision by KEPRO is five business days from the receipt of the request. If a review requires a physician consultation, KEPRO will have one additional business day to render the decision.

All requests for additional information from KEPRO must be received by KEPRO within two business days of the date requested.

Beneficiaries that have other primary insurance will only require Prior Authorization by KEPRO if the primary insurer denies the service and Medicaid is expected to pay as primary.

If a Beneficiary receives Medicaid eligibility after the service has been performed, providers must indicate this at the time of the request. KEPRO will not validate these retro requests, however SCDHHS will audit these cases on a monthly basis.

All hospice services except GIP care may be pre-authorized for up to six months. If the beneficiary is in need of hospice services beyond the initial six months, the hospice provider must submit a new request to KEPRO for an additional six months. Subsequent packets must include the above documentation and be received within 15 days from the termination date of the previous approval date or no later than two days after the termination date.

Upon admission into GIP, prior authorization request must be submitted to KEPRO along with documentation to support the need for such services within five business days. Documentation required for a direct admission into GIP upon the election of the Medicaid hospice benefit includes the Medicaid Hospice Election Form (SCDHHS Form 149), physician's verbal order, the initial care plan or the patient's admission assessment, and supporting documentation. Written certification must be obtained prior to the submission of hospice claims if additional hospice procedure codes are requested for prior authorization. For admissions into GIP after business hours or during holidays, the hospice must submit a request the next business day. GIP care may be pre-authorized for up to 0) days. If the beneficiary is in need of additional care beyond the 30 days, clinical documentation must be received to support the need for continued GIP care.

Hospice room and board services (procedure code T2046) do not require prior approval.

Request for prior authorization for hospice services can be submitted to KEPRO at <http://scdhhs.kepro.com> or by using one of the following methods:

KEPRO Customer Service Phone: 855-326-5219

KEPRO Fax Number: 855-300-0082

Provider Issues email: atrezzoissues@kepro.com

For dually eligible beneficiaries, submit all program-related forms directly to SCDHHS:

SC Department of Health and Human Services

Hospice Program Area

Post Office Box 8206

Columbia, SC 29202-8206

Or

hospiceforms@scdhhs.gov

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ADDITIONAL REQUIREMENTS

REPORTING/DOCUMENTATION

Prior Approval of Services

Services provided by certain Medicaid providers for care not related to the terminal illness must be pre-approved by the hospice provider. The Medicaid provider will contact the hospice provider indicated by the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) to obtain confirmation that the service does not relate to the terminal illness, as well as a prior authorization number to be included on that provider's claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice POC. If the prior authorization number is not included on the claim form, the form will be rejected and returned to the provider. Services that require prior authorization are:

- Hospital
- Emergency Room
- Pharmacy
- Mental Health
- Drug, Alcohol and Substance Abuse Services
- Audiology
- Psychologist Services
- Speech Therapy
- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services
- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry

- Health Clinics
- County Health Departments
- Home Health
- Home- and Community-Based Services
- DME

Non-hospice-related claims for these services will not be reimbursed without the prior authorization number. For example, if a hospice patient is admitted to the hospital for treatment not related to terminal illness, SCDHHS will reimburse the hospital for services directly only if the prior authorization number appears on the claim. The hospice will continue receiving reimbursement from SCDHHS and will be responsible for all other care and services required by the patient during the hospitalization.

All services delivered to hospice patients, regardless of provider, will be subject to post-payment review. A hospice that authorizes Medicaid payment for a service that is related to the terminal illness and that should thus be provided by the hospice is subject to recoupment of the Medicaid funds expended for the service.

A hospice provider must pre-approve all services that are not related to the terminal illness by reviewing a request from other Medicaid providers. In each situation where the hospice provider is authorizing that the service to be performed is not related to the terminal illness, the prior authorization number will be the same number as the hospice provider number issued upon contracting with the SCDHHS. It is necessary for each hospice to maintain a documentation log of each pre-authorization action and to make this documentation available to the staff of SCDHHS upon request. Documentation must include the service that is pre-approved, the service provision date, the Medicaid provider, the approving hospice authority, and the date approval was issued. If a dispute arises regarding whether a prior authorization was obtained, the documentation log will serve as the primary basis in resolving the disagreement.

When a patient leaves a hospital and enrolls in hospice on the same day, the hospice provider must give a prior authorization to the hospital so that the claim for the last day of hospital services can be paid. Conversely, when a patient is discharged or revoked by a hospice program and is admitted to the hospital on the same day, the hospice provider must give a prior authorization to the hospital so that the claim for that day of hospital services can be paid.

The hospice provider must determine which, if any, of the prescription drugs taken by a hospice patient are not related to the terminal illness. The hospice patient's pharmacy must be given a prior authorization number each time the drugs that are not related to the terminal illness are dispensed.

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BILLING GUIDANCE

SPECIAL COVERAGE ISSUES

With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day on which an individual is under the care of the hospice. The four rates are prospective rates established by the Centers for Medicare & Medicaid Services (CMS) for the Medicare hospice program. There will be no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day will vary depending on the LOC furnished to the individual. The limitations on payment for inpatient care are described below.

SCDHHS will not provide payment for Medicaid hospice services where retroactive eligibility has been determined. Please refer to the Provider Administrative and Billing Manual for information on Medicaid eligibility.

LOC

There are four levels of care into which each day of care is classified:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- GIP Care

For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each LOC follows:

Routine Home Care

The hospice will be paid the routine home care rate for each day the patient is at home under the care of the hospice. This includes patients residing in a nursing home. This rate is paid without regard to the volume or intensity of routine home care services on any given day; however, the frequency and intensity of services delivered must be consistent with the patient's POC. The patient's record should include any updates to the POC and changes in the patient's condition between the updates. Also, the patient's record should include all disciplines' daily/weekly/monthly progress notes that record the types and frequencies of the services being provided to the patient.

Continuous Home Care

The hospice will be paid the continuous home care rate when continuous home care is provided.

Continuous home care is to be provided only during a period of crisis. This is defined as a period during which a patient requires continuous care to achieve palliation or management of acute medical symptoms. Continuous home care is primarily nursing care — a nurse must provide the care for more than half of the period of crisis. Nursing care must be provided by either a registered nurse or a licensed practical nurse. A minimum of eight hours of care must be provided during a 24-hour day that begins and ends at midnight. This care need not be continuous; i.e., four hours could be provided in the morning and another four hours in the evening of the same day.

Homemaker and aide services may also be provided to supplement the nursing care.

Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

Documentation should clearly report the reason for continuous home care, list the dates of service and illustrate hour-by-hour and day-by-day what services were provided, the patient's condition and the type of personnel providing the continuous home care.

Inpatient Respite Care

The hospice will be paid at the inpatient respite care rate for each day that the beneficiary is in an approved inpatient facility and is receiving respite care.

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis.

Services provided in the facility must conform to the hospice's POC. Payment for respite care may be made for a maximum of five consecutive days at a time including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Documentation in the beneficiary's record should reflect why the respite care was necessary. If there is more than one respite care admission in a short amount of time, documentation should indicate why multiple admissions were necessary.

GIP Care

Payment at the inpatient rate will be made when GIP care is provided for services related to the terminal illness. No other fixed payment rate (i.e., routine home care) will be applicable for a day that the patient receives hospice inpatient care. Services provided in the inpatient setting must conform to the hospice's POC. The hospice must have a contract with the inpatient facility delineating the roles of each provider in the hospice's POC; however, the hospice is the professional manager of the patient's care, despite the physical setting of that care or the LOC. GIP

care is a short-term LOC and is not intended to be a permanent solution to a negligent or absent caregiver. Documentation in the beneficiary's record should clearly explain the reason for the admission and the beneficiary's condition during the stay in the facility at this LOC. The key to GIP LOC is the patient's medical condition.

Date of Discharge

The appropriate routine home care rate is to be paid for the day of discharge from an inpatient unit. If the patient dies in the inpatient unit, the appropriate rate (general or respite) is to be paid for the discharge date.

Hospice Payment Rates

The federal hospice rates are issued each year, effective October 1, by CMS and adjusted for local wage indices. The SCDHHS Division of Ancillary Reimbursement, in conjunction with the hospice program manager, will notify each hospice of the approved Medicaid hospice reimbursement rates.

Limitation of Payments for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for GIP care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid beneficiaries during that same period. This calculation will exclude days for beneficiaries afflicted with Acquired Immune Deficiency Syndrome.

This limitation is applied once each year, at the end of the hospices' "cap period" (November 1–October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a routine home care rate will not be counted as inpatient days. The limitation is calculated as follows:

- The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
- If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.
- If the total number of days of inpatient care exceeds the maximum allowable number, the limitation will be determined by calculating the ratio of the maximum allowable days to the number of actual days of inpatient care and multiplying this ratio by the total reimbursement that was made for inpatient care (GIP and inpatient respite reimbursement).
 - Multiply excess inpatient care days by the routine home care rate.
 - Add together the amounts calculated in 1 and 2 above.

- Compare the amount in 3 above with interim payments made to the hospice for inpatient care during the “cap period”.

Any excess reimbursement will be recouped from the hospice by SCDHHS.

Payment for Physician Services

SCDHHS will pay the physician in accordance with the usual South Carolina Medicaid reimbursement methodology for physician services regardless of whether services are provided by a hospice employee, a physician under agreement with the hospice or the patient’s attending physician for related or non-related services. Services furnished voluntarily by physicians are not reimbursable.

Physicians’ administrative services provided by the hospice medical director or physician member of the interdisciplinary group, such as general supervisory services or participation in the establishment of POC, supervision of care and services, periodic review and updating of care plans and establishment of governing policies, are included in the daily hospice reimbursement rate and not eligible for the physician’s fee-for-service reimbursement.

The hospice must notify the Medicaid hospice program manager of the name of the physician who has been designated as the attending physician by the beneficiary. This information is included on the Medicaid Hospice Election Statement.

Payment for Facility Residents

When a Medicaid beneficiary who is a NF or ICF/IID resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit, Medicare becomes the primary payer for the hospice benefit. For either a Medicaid only or a dually eligible resident, the state Medicaid agency must pay the hospice agency for the facility room and board payment.

When presented with a reimbursement claim, SCDHHS will directly reimburse the hospice agency an amount no less than 95% of the daily Medicaid rate of reimbursement for the room and board of the patient receiving hospice. The hospice must reimburse the facility according to the terms specified in their contract arrangements.

This rate is designed to cover room and board, which includes the following:

- Performance of personal care services.
- Assistance in the activities of daily living.
- Administration of medication.
- Maintaining the cleanliness of the patient’s environment.
- Supervision and assistance in the use of DME and prescribed therapies.

Along with this reimbursement, SCDHHS will reimburse the hospice provider the daily rate for hospice care provided and billed on the CMS-1500.

Payment/Sponsorship Guidelines for Hospice in a NF or ICF/IDD

ELIGIBILITY STATUS	NF SPONSORSHIP	HOSPICE SPONSORSHIP	COMMENTS
Dual	Medicare	Medicare	Rare — In NF for a diagnosis code related to the terminal illness. NF can bill Medicare for room and board using modifier 07.
Dual	Medicare	Private	No Medicaid Payment for hospice.
Dual	Medicaid	Medicare	Medicare becomes the primary hospice payer.
Medicaid Only	Medicaid	Medicaid	SCDHHS reimburses the hospice agency for the Medicaid room and board rate.

Note: Medicaid is always the payer of last resort.